DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 00-009

2. STATE: Idaho

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

OCT 2 2000

ORIGINAL

4. PROPOSED EFFECTIVE DATE
July 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 441 Subpart A

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ -0-
b. FFY 2001 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment to Amendment 3.1.A.7C Pages 3 - 4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment to Amendment 3.1a.7c pages 3-4

10. SUBJECT OF AMENDMENT:
Wheelchair Rental Requirements

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Karl B. Kurtz

13. TYPED NAME:
KARL B. KURTZ

14. TITLE:
Director

15. DATE SUBMITTED:
September 29, 2000

16. RETURN TO:
Joseph R. Brunson, Administrator
Idaho Dept of Health and Welfare
Division of Medicaid
PO Box 83720
Boise ID 83720-0036

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: OCT 2 2000

18. DATE APPROVED: NOV - 6 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 1 2000

20. SIGNATURE OF REGIONAL OFFICIAL:
Teresa L Trimble

21. TYPED NAME:
Teresa L. Trimble

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID

23. REMARKS:
POSTMARK: 9/29 (DATE) • BOISE (CITY/STATE)

FORM HCFA-179 (07-92)

Instructions on Back

iv. Electric or hydraulic patient lift devices designed to transfer a person to and from bed to bathtub, but excluding lift chairs, devices attached to motor vehicles, and wall mounted chairs which lift persons up and down stairs; and (7-1-99)

v. Grab bars for the bathroom adjacent to the toilet and/or bathtub; and (11-1-86)

vi. Hand-held showers; and (11-1-86)

vii. Head gear (protective); and (7-1-99)

viii. Hearing aids (see Section 108 for coverage and limitations); and (7-1-99)

xi. Home blood glucose monitoring equipment; and (11-1-86)

x. Intravenous infusion pumps, and/or NG tube feeding pumps, IV poles/ stands, intrathecal kits; and (7-1-99)T

xi. Hand-held nebulizers, air therapy vests, and manual or electric percussor; and (7-1-99)T

xii. Medication organizers; and (1-1-98)T

xiii. Oxygen concentrators; and (11-1-86)

xiv. Pacemaker monitors; and (11-1-86)

xv. Compressors and breathing circuit humidifiers; and (7-1-99)T

xvi. Sliding boards and bath benches/chairs; and (11-1-86)

xvii. Suction pumps; and (11-1-86)

xviii. Sheep skins, foam or gel pads for the treatment of decubitus ulcers; and (7-1-99)

xix. Traction equipment; and (7-1-99)

xx. Walkers; and (7-1-99)T

03. Coverage Conditions – Equipment. The following medical equipment is subject to the following limitations and additional documentation requirements: (7-1-99)

a. Wheelchairs. The Department will provide the least costly wheelchair which is appropriate to meet the recipient's medical needs. The Department will authorize the purchase of one (1) wheelchair per recipient not more often than once every five (5) years. Specially designed seating systems for wheelchairs shall not be replaced more often than once every five (5) years. Wheelchair rental or purchase requires prior authorization by the Department or its designee and shall be authorized in accordance with the following criteria: (7-1-00)T

i. In addition to the physician's information, each request for purchase of a wheelchair must be accompanied by a written evaluation by a physical therapist or an occupational therapist. The evaluation must include documentation of the appropriateness and cost effectiveness of the specific wheelchair and all modification and/or attachments and its ability to meet the recipient's long-term medical needs. For each request for a rental of a wheelchair, a physical therapist or an occupational therapist evaluation may be required on a case-by-case basis, to be determined by the Department or it's designee; (7-1-00)T

ii. Manual wheelchairs will be authorized based on the recipient's need according to the following criteria: (1-1-98)T

(1) The recipient must be nonambulatory or have severely limited mobility and require a mobility aid to participate in normal daily activities and the alternative would be confinement to a bed or chair; (1-1-98)T

(2) A standard lightweight wheelchair will be authorized if the recipient's condition is such that he cannot propel a standard weight wheelchair; (1-1-98)T

(3) An ultra light weight wheelchair will be authorized if the recipient's conditions are such that he cannot propel a lightweight or standard weight wheelchair. (1-1-98)T

iii. Electric wheelchairs are purchased only if the recipient's medical needs cannot be met by a manual wheelchair. The attending physician must certify that the power drive wheelchair is a safe means of mobility for the recipient and all of the following criteria are met: (1-1-98)T

(1) The recipient is permanently disabled; and (1-1-98)T

(2) The disability is such that, because of severe upper extremity weakness or lack of function, the recipient cannot operate any manual wheelchair. (1-1-98)T

iv. Additional wheelchairs may be considered within the 5 year limitation with written documentation from the physician and a written evaluation from a physical therapist or an occupational therapist indicating that the current wheelchair is longer meets the client medical needs (7-1-99)T

(1) may actually be damaging to the clients medical condition (7-1-99)T.

b. Electronic blood glucose testing devices with voice synthesizers must be prior authorized by the Department or its designee and are covered only when the following documentation is submitted and verified by the attending physician: (4-1-98)T

i. The recipient has been determined to be legally blind and is unable to read a standard glucose monitor (this does not include any correctable vision defects; (and) (1-1-98)T

ii. The recipient lives alone or has no care giver available during the times when the glucose testing must be done. (1-1-98)T

c. Electronic pain suppression/muscle stimulation devices TENS Units must be prior authorized by the Department or its designee and are purchased only when the effectiveness of such devices is documented by the physician and only after: (4-1-98)T

i. The pain has been present for a minimum of three (3) months; and (1-1-98)T

ii. Other treatment modalities have been tried and failed (documentation must be submitted with request for prior authorization; and (1-1-98)T

iii. The effectiveness of the device is documented following a maximum of a two (2) month trial rental period; and (1-1-98)T